1. Key development issues and rationale for Bank involvement

Brazil has made significant progress in human development over the last decade, reflecting gains in health status, education attainment and social assistance. Significant challenges remain, however. Although poverty decreased by 11 percent during the last 12 years, a quarter of the population (about 45 million) still lives below the poverty line. Brazil also remains one of the most unequal countries in the world. Health, education and social services suffer from serious inefficiencies, which increasingly threaten the affordability and sustainability of these systems. Given budgetary constraints, a case can be made that without improvements in the efficiency and quality of service delivery, equity gains may remain elusive.

Health status has significantly improved in the last 10 years – infant mortality decreased by 47 percent in 14 years (from 47.5 per 1,000 live births in 1990 to 25.3 per 1,000 live births in 2004); mortality rates from vaccine-preventable diseases in children are negligible; and diarrheal diseases are the cause of less than 7 percent of all deaths among children under 5. The number of new cases of HIV/AIDS has leveled off in part due to an aggressive prevention, promotion and treatment system.

Despite these advances, significant system shortcomings persist:

- **Inequities**: Substantial disparities still exist in health status, health financing and service utilization among regions, states and municipalities within states, income groups, and between urban and rural areas.

- **Inefficiencies**: Government is the predominant payer of health services in Brazil. Growing demand and new technologies will continue to exert pressure on the public purse. Yet little attention has been paid to cost containment. Brazil’s delivery system remains hospital- and specialty- centered, compromising the affordability and sustainability of the delivery system. Only about 40 percent of Brazilians have regular access to more affordable primary health care. Coverage is lower in large cities, particularly in low-income favelas. Cities with high
primary care coverage also show significantly lower utilization rates of more costly outpatient specialty consultations, often provided in hospitals, than cities with low primary care coverage (Viana, et al., 2002). Further, about 30 percent of hospital admissions, representing 21 percent (US$2.8 billion) of public spending on hospitals (15 percent of total public spending in 2002) are for care that can more effectively and efficiently be provided at lower levels of the delivery system. The average cost of treatment for basic care is US$374 at a hospital setting compared to approximately US$17 at ambulatory facilities. Cities with high primary coverage display lower rates of hospital admissions for children with acute respiratory infections and diarrheal diseases (Sales and Gentile, 1998; Carvalho, 2005). Finally, publicly-financed facilities suffer from productive inefficiencies resulting in huge cost variations among providers. This results in part to insufficient use of practice guidelines and clinical protocols (World Bank, 2004).

- **Quality and Effectiveness Problems**: Non-communicable diseases are now the main cause of death and disease in the country, accounting for 62 percent of all deaths, which has a significant impact on health care costs and the economy. A recent study found that continuing with the status quo will add US$ 34 billion to the country’s health care bill over the next five years, and also result in economic costs of US$38 billion in lost productivity (World Bank, 2005). Taken together, the financial and economic costs represent about 10 percent of GDP in 2003. Status quo refers to under-provision of health promotion and prevention interventions, the weakness of referral systems, lack of dissemination and use of cost-effective treatments, and the absence of functional networks to facilitate the application of case management protocols across all levels of care. Quality of health care is generally unknown or low, particularly in facilities serving poor populations (World Bank, forthcoming).

The Bank has supported the Brazilian *Reforma Sanitaria* since its inception through a series of health investment projects that address both health status and health system priorities. Analytical work carried out by the Bank has supported both the design of lending operations and the formation of public policies. The Human Development PSRL II (FY06) provides the umbrella policy framework for the Bank’s assistance to human development in Brazil. A trigger for the HD PSRL I was expansion of the Family Health Program to 50 percent of the population, with priority given to poor populations residing in rural and large urban areas. The program has expanded from 32 percent to 41 percent, but it is unlikely to reach the trigger until late 2006. Continued Bank support in this area is necessary to ensure that coverage targets are achieved.

### 2. Proposed objective(s)

The Brazil Family Health Extension Project (PROESF) is a 7-year Adaptable Program Lending (APL) in three phases. The overall APL Program objectives are:

(a) Expand population coverage of PSF to about 100 large, urban municipalities;¹

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¹ According to the original design, Phase I (PROESF I) was to extend coverage to 40 municipalities, and Phase II (PROESF II) to an additional 60. Phase III would support consolidation of PSF in the 100 municipalities. However, the Government has decided to expand coverage under Phase I, and the project currently supports 177 municipalities with more than 100,000 inhabitants.
(b) Establish family health as a core element of health professional and para-professional training; and
(c) Strengthen MoH capacity to monitor and evaluate PSF health services, policies and training activities on a systematic basis.

Consonant with these Program objectives, the objectives of the proposed second phase project are:

(a) Increase access to PSF-based care in large, urban municipalities;
(b) Raise the technical quality of and patient satisfaction with PSF-based care;
(c) Improve the efficiency of PSF service providers as well as the broader delivery system;
(d) Improve the effectiveness of the overall health delivery system.

Means to achieve these objectives include: scaling up the Family Health Program in large urban centers; applying quality of care certification mechanism; strengthening in-service and pre-service training of personnel; establishing referral and counter-referral linkages between family health teams and the broader network of health providers; strengthening monitoring practices and systems in states; introducing results-based management and financing mechanisms; increasing the provision of on-demand morbidity; strengthening health promotion and management of chronic diseases; making care more accessible for disabled Brazilians; and supporting systematic impact evaluation.

3. Preliminary description

The second phase will consist of three components:

Component 1. Expansion and Consolidation of Basic Health Care (estimated total cost US$145 million): This Component would support: (i) the extension of Family Health to municipalities where this model has not yet been adopted or is at an initial phase of implementation; (ii) continued expansion of the model in municipalities that have already made significant headway on family health, but have yet to attain coverage targets; and (iii) consolidation and innovation in municipalities that have shown significant progress in implementation of family health in the first phase. This Component would include four subcomponents: (i) expansion and quality improvement of family health and development of basic health networks; (ii) support for municipal-based in-service training; (iii) strengthening municipal management of family health; and (iv) improvement of monitoring and information systems. All financing will be channeled to municipalities through a pooled funding (SWAp approach). The Component would finance works (rehabilitation), goods, training and technical assistance.

Component 2. Family Health Human Resources Development (estimated total costs: US$48 million). This Component, which would be implemented at the central level, aims to strengthen the supply, quality and stability of Family Health human resources. The Component would include three subcomponents: (i) pre-service formation and continuous education of family health professional staff; (ii) specialization, residencies and post-graduate research for Family
Health physicians and nurses; and (iii) special activities to support develop professional participation and ownership of the Family Health Program, including demonstration projects to develop and implement improved curricula and establish links between medical/nursing schools and family health teams; annual conferences to share experiences and innovations; national and international study tours; and development of textbooks and training materials. Implemented directly by the MoH, this Component would finance goods, training, and technical assistance.

**Component 3. Family Health Monitoring and Evaluation** (estimated total cost: US$48 million). This Component aims to establish systematic monitoring of Family Health performance at the state and federal levels while supporting continuous impact evaluation. The Component would include two subcomponents: (i) institutionalization of monitoring of Family Health in the states; and (ii) institutionalization of Family Health monitoring and impact evaluations in the MoH. These subcomponents would include the following activities: (i) upgrading the Basic Care information system (SIAB); (ii) revising the indicators of “basic care compact” for federal monitoring of municipal performance; (iii) evaluation of in-service and pre-service training; (iv) piloting of mechanisms linking quality improvement to financing; and (iii) evaluation of basic care information systems. In the first subcomponent all financing will be channeled to states through a pooled funding (SWAp approach). The second subcomponent will be implemented centrally. The Component would finance goods, training, technical assistance, and the project operational costs.

**4. Safeguard policies that might apply**

At this stage, since the project is likely to have minimal environmental impacts, the team recommends classifying it into Category “C” for environmental aspects. As in the first phase, project’s activities involve small civil works (rehabilitation), purchase of goods, training, and technical assistance. In addition, given the reorganization of the health care model, extending family health coverage may increase generation of waste material at municipalities’ basic health units, which would call for more effective controls. On the other hand, positive impacts may also be generated in the long-term due to a decrease in the number of inpatient days and emergency consultations for treatments that are provided at basic health units. This could result in the decline the volume of generated waste. More effective implementation of medical waste management systems in basic care units would have a positive environmental impact. The project will focus on large urban centers and will have relatively little impact on indigenous peoples. The BR VIGISUS II project, currently under implementation, supports health care for indigenous people.

**5. Tentative financing**

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**6. Contact point**

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